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Moving away from medicalised and partisan terminology: a contribution to the debate

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ABSTRACT

There is a growing awareness within both mental health and substance misuse services of the importance of co-existing problems. Clients with these co-existing problems impact upon a wide range of professionals, and often present major challenges due to their complex needs.

However, there is confusion about both terminology, and many of the underlying and treatment issues, related to these co-existing problems.

This paper examines some of these confusions and debates, arriving at the view that practice in the field will be enhanced by the adoption of a broad and inclusive definition of co-existing problems which avoids medicalised terminology such as 'dual diagnosis' or 'co-morbidity'. We argue that the term 'co-existing mental health and drug and alcohol problems' is consistent with a case formulation driven approach and adoption of this term will thus enhance practitioners' confidence in the detection, assessment and treatment of co-existing problems.

KEY WORDS

Dual diagnosis; Co-morbidity; Co-existing problems; terminology

INTRODUCTION

There are very large numbers of people in the community who experience both common mental health and drug and alcohol disorders (Regier, Farmer, Rae, Locke, Keith, Lewis & Goodwin, 1990). That USA-based study showed that, among people with any lifetime mental disorder (other than a substance use disorder), over a quarter (29%) had a lifetime history of some substance use disorder: 22% had an alcohol use disorder and 15% had another drug use disorder. Conversely, among individuals with a lifetime alcohol use disorder, 37% had at least one other (non-substance use) mental disorder and 53% of those with a lifetime drug use disorder had at least one mental disorder other than alcohol use disorder. Of individuals with a lifetime history of alcohol disorder, 45% had a co-existing mental or other drug disorder and 72% of those with any drug disorder had a co-existing mental or alcohol disorder. Highest rates of alcohol or other drug use disorders were found among people with antisocial personality disorder (84%), followed by bipolar disorder (61%), schizophrenia (47%), affective (32%) and anxiety disorders (24%). The most prevalent co-existing mental disorders among people with an alcohol disorder were: anxiety disorders (19%), antisocial personality disorders (14%), affective disorders (13%) and schizophrenia (4%). The most prevalent mental disorders among those with any drug use disorder were: anxiety disorders (28%), affective disorders (26%), antisocial personality disorder (18%) and schizophrenia (7%) (Regier et al., 1990).

However, there is significant confusion over both what is meant by ‘co-existing problems’ and over what terminology might be most appropriate and useful to use when discussing this issue. Commonly, the number and severity of symptoms

associated with mental health and co-existing substance use problems may not reach formal diagnostic threshold for mental or substance use ‘disorders’. However, these sub-threshold problems can significantly interfere with levels of functioning (Kavanagh, Mueser & Baker, 2003). This complexity in clinical presentation is not well described by existing terminology (e.g, dual disorder, dual diagnosis, co-morbidity) and is associated with significant uncertainty regarding appropriate intervention.

The present paper examines why existing terminology may not be clinically useful and suggests alternative terminology as a step towards enhancing practitioner confidence in working with such complex presentations.

THE GROWING AWARENESS AND IMPORTANCE OF CO-EXISTING PROBLEMS

The concept of co-existing problems (sometimes called dual diagnosis or co-morbid problems, see below) with mental health and substance use has gained prominence in the last few decades, for a number of reasons (Abou-Saleh 2004; Crawford & Crome 2001; O'Brien *et al.* 2004). These include: the increasing availability and accessibility of alcohol and illicit drugs within the community; deinstitutionalization of people with severe mental health problems; and increasing expectations that agencies will address co-existing problems, despite deficits in staff training and organizational constraints limiting interface between services.

Clients with co-existing problems impact upon the range of professionals working within mental health services, alcohol and drug services, and a variety of agencies in the statutory and non-statutory sectors. Clients who have co-existing problems often present the social rehabilitation service network with a major challenge, as their individual needs in medico-psycho-social terms, and their collective needs in organisational terms, are both complex and highly demanding. Further, in economic terms, this group has significantly higher overall healthcare costs than those with either substance use or mental health problems alone (Hoff *et al.* 1998; Hoff *et al.* 1999).

Because many of these clients will have lost touch with (or have been discharged from) specialist medical, psychiatric and addiction services, these clients also often pose particular difficulties for the non-statutory sector and for primary care, both of whom often feel they are having to cope ‘as best as they can’. This creates a paradox: the services within which the staff are meant to have higher levels of skill in dealing with complex problems have tended to discharge or lose contact with these clients, and hence the ‘safety net’ services where staff often have lower levels of training are the ones that have primarily to deal with these complex problems.

In summary then, co-existing problems with both substance use, and one or more of a range of mental health issues (anxiety, depression, schizophrenia, bipolar disorder, etc) are highly prevalent, often begin in youth, and place an immense burden on individuals, families, and society. Because of the severity of these co-existing problems, and the fact that many services do not deal adequately or appropriately with them, co-existing problems are associated with underachievement or failure for

affected individuals across many domains, including academic, employment, relationship, social and health; and with greater involvement with the criminal justice system, with failed treatment attempts, with poverty, and homelessness. Finally, the risk of suicide is high for persons with co-existing mental health and substance use problems.

Co-existing mental health and drug and alcohol problems are so common that in clinical settings, a large proportion of presentations can be assumed to have such problems. Despite this, clinical services are separated along mental health and drug and alcohol lines and clinicians have rarely been trained in how to detect, assess and formulate interventions for co-existing problems. Consequently, people with co-existing mental health and drug and alcohol problems often do not receive optimal treatment. There may be considerable delay in commencement of treatment whilst clinicians seek to establish a 'primary' diagnosis (Westermeyer, Weiss & Ziedonis, 2003), often involving referral between different services. In our view, this is poor clinical practice. We argue (Baker & Velleman, 2007) that detecting, assessing and treating co-existing mental health and drug and alcohol problems is the clinical responsibility of both mental health and drug and alcohol teams. All mental health and all drug and alcohol teams should be able to detect and assess symptoms of problems in both domains, and offer treatment for presenting symptoms. Where both mental health and drug and alcohol problems are severe (for example, in the case of severe depression and alcohol dependence), treatment by only one team is recommended, in consultation with specialists in the other domain if necessary.

WHAT IS MEANT BY ‘CO-EXISTING MENTAL HEALTH AND DRUG AND ALCOHOL PROBLEMS’?

We are referring in this paper to ‘co-existing mental health and drug and alcohol problems’ as situations where people have problems related *both* to their use of substances (from hazardous through to harmful use and/or dependence) *and* to their mental health (from problematic symptoms through to highly prevalent conditions such as depression and anxiety, to the low prevalence disorders such as psychosis). We are also referring to substance use which might be of alcohol, tobacco, illicit drugs and/or use of prescribed or over-the counter medications.

This definition above and our use of the term ‘co-existing’ is a broad and inclusive one, and this is deliberate. There seem to us to be many reasons for using such a broad, inclusive approach; with the main reasons relating to two issues. First, because co-existing mental health and substance use problems are an extremely heterogeneous category, the broadest and most inclusive definition is the most helpful. Second, given this heterogeneity, the emphasis needs to be on individualized assessment and formulation, and the terminology needs to orient practitioners towards such individualisation and not towards a diagnostic approach.

WHAT TERMS SHOULD WE USE TO DESCRIBE THESE ‘CO-EXISTING PROBLEMS’?

This is an area where there are many debates about terminology, and underlying these are issues of professional power and control.

We advocate the use of the term ‘co-existing problems’. This is for a number of reasons.

- ‘Co-existing’ is a simple statement of fact. It contains within it no suggestions that one set of problems ‘caused’ the other set, or were the ‘result’ of the other set. In any individual case it may of course be true that one set of problems *did* cause the other, or that use of a substance *did* lead to or exacerbate an existing mental health problem, or that the mental health problem of an individual *did* lead to that individual self-medicating, or even that the two sets of problems are completely unrelated. But the fact that all of these possibilities will be true in some cases does not mean that any of them are true in all cases; and hence a simple statement of the fact of co-existence seems to us to be more helpful than using any of a number of alternative terms which carry with them all sorts of baggage.
- A further reason is that, as clinicians, we take a symptom-focused and problem-oriented view of such problems (Velleman, 2001); and as such we prefer to concentrate on the problems that our clients report and experience, and not on whether or not these problems are diagnosable. Our orientation is to focus on individualized assessment and formulation. We advocate an approach focusing on a specific case formulation, and the development of treatment or intervention plan based on that formulation, addressing factors which maintain these specific co-existing problems. Treatment of co-existing problems may, but not necessarily will, involve attempting resolution of one problem before another, or may involve addressing co-existing problems simultaneously, depending on the case formulation (Baker, Kay-Lambkin and Lewin, 2007). As is the case with single problems such as anxiety or depression, treatment for co-existing problems based

on case formulation involves collaboration with the client. Treatment does not involve a 'cure' of a diagnosable disease, nor does it always require abstinence from alcohol or other drugs. It will draw upon the evidence base for each presenting problem and any evidence (although this is currently minimal) for the treatment of co-existing problems.

- A final reason is that, clumsy though it is, the term 'co-existing mental health and drug and alcohol problems' carries no allegiance to any professional group or source of institutionalised power, which is not the case with many of the other terms in general use at present.

One common set of terms used to describe similar territory is 'dual diagnosis', referring broadly to the concurrent existence in an individual of two psychiatric diagnoses: a substance use disorder and one or more psychiatric disorders. We do not favour this term, for a number of reasons:

- The term implies a medicalised viewpoint (diagnosis has historically been under the control of medically trained professionals), and this is not our perspective, nor the perspective of many social and health care staff, nor of most service users.
- Dual diagnosis focuses on the 'diagnosis' aspect, and yet for us the issue is the problems these people have (both two separate sets of problems, and also in the situations where the two sets of problems may have a multiplicative effect), not on whether any individual has the necessary symptoms in the correct patterns to receive two different psychiatric diagnoses.
- Mental disorder and substance misuse are different types of problem, each with its

own continuum of severity from mild to severe. At what point does an individual cross a threshold with each of these problems to be considered as having a 'dual diagnosis'? These thresholds will be partly determined by 'existing beliefs about the benefit of therapeutic input, what constitutes harmful substance misuse, and what is meant by mental disorder' (Banerjee et al, 2002, p2).

- Related to this latter point, 'dual diagnosis' can be taken to imply the fulfilment of these two (and only two) sets of diagnostic criteria; whereas many people experience more than two co-existing problems without necessarily meeting formal diagnostic criteria for all of them at the same time. It also implies that the person has only the two sets of problems, one concerned with substance use, the other with their mental health symptoms. In reality, people given the label 'dual diagnosis' typically have complex needs rather than two distinct problems. The focus on substance misuse and mental health problems may mean that other areas of concern are missed such as a history of childhood sexual abuse, housing issues, or child protection issues. As one service user quoted by Hawkins and Gilburt (2004, p2) said:

'Dual diagnosis is a label they give you, but even at my most buoyant I think I've got more than two problems'

- A diagnostic approach brings with it a focus on 'primary diagnosis'. Treatment services and providers tend not to be sensitive to the severity and consequences of co-existing problems among their clients and tend to consider one problem secondary to another (Havassy, Alvidrez & Owen, 2004). This approach usually leads to clinical confusion and even frustration, as the relationship between co-existing problems is commonly one of mutual influence, with no clear primary problem (Mueser, Drake & Wallach, 1998); and the relationship between

problems may change over time (Kavanagh et al., 2003). For example, depression may trigger alcohol use at times, whilst heavy drinking may precipitate depressive symptomatology at others (Hodgkins, el-Guebaly, Armstrong & Dufour, 1999). In addition, as stated above, the pursuit of a primary diagnosis can result in the suspension of treatment plans until diagnostic clarity is reached and then whilst the 'right' service is sought to match this 'primary' diagnosis (Westermeyer, Weiss & Ziedonis, 2003). This often results in both treatment providers and clients becoming confused about optimal treatment. Furthermore, it is usually the case that by the time someone is referred into specialist services, both problems are of sufficient magnitude as to need help. Alternatively, services involved may try to split the problems in order to deal with both in parallel, but the problems are likely to be intertwined within that individual.

- It is also the case that staff's attribution as to whether the primary diagnosis is 'substance misuse' or 'mental illness' will often depend on the knowledge and experience of the assessor, and the method of assessment. Furthermore, it is also likely (given clinicians' lack of training and knowledge about the 'other' problems which they have not specialised in) that staff from mental health services may be more likely to attribute presenting problems to substance use and vice versa, so shifting responsibility for the case from themselves to the other service.
- The term is inexact: it could apply to any two diagnoses, not only the ones we are referring to in this paper. Indeed, 'dual diagnosis' has been applied over recent years to a number of different groups of people with two co-existing conditions such as personality disorder and mental health problems or learning disability and mental disorder.

- The term ‘dual diagnosis’ has a ‘fixed’ quality (one’s symptoms make a pattern which is diagnosable or not); but in reality people’s substance misuse and mental health problems usually vary over time. For example:
 - People may vary the type and amount of substances they use, e.g. they may stay clear of opiates or cocaine but use alcohol or cannabis occasionally
 - They may react differently to the same substance depending on its quality, their environment, their mood or state of mind, or their general health
 - Their mental health problems may fluctuate, e.g. they may have episodes where their problems are very pronounced followed by long periods of stability
 - Their vulnerability may fluctuate, e.g. a person may be especially vulnerable to using alcohol during periods of paranoia, or of mania (Hawkins and Gilbert 2004).
- The label ‘dual diagnosis’ implies that there is a homogenous group of clients with similar problems. In reality, people with co-existing problems are a very mixed group.
- A final reason why we favour looking at ‘problems’ as opposed to ‘diagnoses’ is that, even if the term ‘diagnosis’ was acceptable, the relationship between problems and diagnosis may be unclear within this population. There may be many instances whereby a co-existing mental disorder (or even the medication being taken to help control psychiatric symptoms) may mean that any given amount of alcohol or of a drug might have a different or far greater effect than it might on other people. Similarly, there may be many instances where the use of alcohol or a drug may cause mental health problems to occur, some of which may

be short-lived, others of which may trigger chronic and severe mental health problems (e.g. psychosis).

The UK Department of Health Good Practice Guide (2002, p 7) describes a simple set of four possible relationships:

- ‘A primary psychiatric illness precipitates or leads to substance misuse
- Use of substances makes the mental health problem worse or alters its course
- Intoxication and/or substance dependence leads to psychological symptoms
- Substance misuse and/or withdrawal leads to psychiatric symptoms or illnesses’.

Each of these relationships occur very frequently, but even this set does not cover all eventualities (for example, the development of both sets of problems might be independent of each other).

Another term which is widely used is ‘*co-morbidity*’, but again this puts the emphasis on the ‘morbid’ processes and diagnostic categories, and not on a simply delineation of the range and extent of problems which someone’s mental health difficulties or substance use behaviours are causing them. And again, as with ‘dual diagnosis’, co-morbidity is a highly medicalised term, used primarily within the medical profession and used primarily to describe a person who has two medical conditions existing simultaneously but independently. Hence many of the arguments outlined above for why the term ‘dual diagnosis’ is less useful in describing this population apply equally when using ‘co-morbidity’.

Other terms which have been used to describe this population, include: *dual disorder*; *mentally ill chemical abuser* (MICA); *chemically addicted mentally ill* (CAMI); and *co-occurring addictive and mental disorders* (COAMD).

GIVEN THIS CONFUSION, WHAT DO WE SUGGEST?

We recognise that, at present, the term dual diagnosis is the most widely recognised and used term for this group, internationally, even though for the reasons we have given above we feel that it is very inadequate.

As outlined above, our position is that since co-existing mental health and substance use problems are an extremely heterogeneous category, the broadest and most inclusive definition is the most helpful. Given this heterogeneity, the emphasis needs to be on individualized assessment and formulation.

For the reasons given above, therefore, we favour the use of the term ‘co-existing mental health and substance use problems’ or ‘co-existing mental health and drug or alcohol problems’. We do accept that this term is rather clumsy, but we feel that it is greatly superior to the alternatives. Accordingly, we argue that this should be adopted as a universally agreed term, which reflects the multifaceted needs of individuals experiencing co-existing substance use and mental health problems.

CONCLUSION

Partly because clients with these co-existing problems impact upon a wide range of professionals, and often present major challenges due to their complex needs, there is a growing awareness within both the mental health and substance misuse fields of the importance of co-existing problems. However, often the complex and interrelated nature of these clients' problems are not detected.

In this paper we have looked at many of the issues which lie at the heart of how co-existing problems are conceptualized. There are many debates about the appropriateness of various ways of describing people with co-existing problems with their mental health and their substance use. We favour a broad and inclusive definition of co-existing problems. There is a need to deliberately move away from such medicalised terminology as 'dual diagnosis' or 'co-morbidity' in order to enhance clinician confidence in the detection, assessment, case formulation and treatment of co-existing problems.

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